BOSTON UNIVERSITY
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A SOCIAL STUDY OF TWENTY-FIVE CASES OF STUTTERING KNOWN AT A CHILD GUIDANCE CLINIC

A Thesis

Submitted by

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CHAPTER I

INTRODUCTION

Many large studies have been made on the prevalence of stuttering. Results differ somewhat, but give some conception of the size of the problem. According to Fletcher, studies show a prevalence ranging from Blanton's study in Madison, Wisconsin, where in the school grades .72 per cent of the children were found to be stutterers, to Camp's study where among Grand Rapids children 2.64 per cent were found to be stutterers.[1] Heltman states that one child out of every hundred will become a stutterer by the law of averages,[2] which agrees with the figure Fletcher achieves when taking the average of various findings.

Stuttering has been known since events recorded in the Egyptian hieroglyphics.[3] Yet even as late as the 1920's Fletcher found among child welfare organizations listed in the Red Cross Handbook of Social Resources of 1921 that not a single organization had done anything regarding this problem.[4]

In the last twenty years many investigators from different fields have turned their attention to the study of stuttering, but as Meltzer states, "a review of the literature suggests the presence of an over-

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1 John Madison Fletcher, The Problem of Stuttering, p. 55.

2 Harry Joseph Heltman, First Aids for Stutterers, p. 39.

3 Fletcher, op. cit., p. 1.

4 Ibid., pp. 23-26.

abundance of distinctive conceptions".[5] Hahn writes:

> It is generally recognized by speech pathologists that research programs are needed for the purpose of investigating the various statements made by those who have theories as to the nature and treatment of stuttering.[6]

He feels two aspects of the problem need further investigation: (1) evaluation of the effect of remedial procedures upon stuttering, and (2) analysis of stuttering factors in cases of large numbers of stutterers, both young and adult.[7]

Various approaches today to the problem of stuttering are made from psychological, physiological, psychiatric, and social aspects. Different focuses are given weight by separate investigators.

This present study is made from only one approach, the social one. It is a study of the social situation in the lives of twenty-five children in whom stuttering occurred of such a nature that they were referred to a child guidance clinic. An examination is made of the personalities of these children and their social adjustment at home, in school, and with friends. Closely bound with this is a study of the surrounding social environment and its influence on and interaction with the child's personality. Are there adverse social factors operating on the children? In light of the difficulty of stuttering, how does this factor affect the children's lives and their social adjustment? Secondarily considered is

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5 H. Meltzer, "Personality Differences among Stutterers as Indicated by the Rorschach Test", American Journal of Orthopsychiatry, 4:262, April, 1934.

6 Eugene F. Hahn, Stuttering: Significant Theories and Therapies, p. 165.

7 Ibid., p. 166.

the existence of other factors thought by some investigators to contribute to or underlie stuttering.

The data have been secured from the files of the Massachusetts Child Guidance Clinics. All cases were "full service" cases where a speech examination had been given by the clinic speech training teacher. "Full service" means the cases were taken on for clinic treatment and a thorough examination made of the child's life and environment. The records include for each case a full social service history made by a psychiatric social worker, a psychological examination of intelligence, a psychiatric examination, and a speech examination by the speech therapist. Also included are social adjustment notes, treatment summaries, and speech therapy notes. All cases were closed at the time of this study. Cases were chosen consecutively from March, 1937, to February, 1938, on the basis that the factor of stuttering existed, that they were "full service" cases, and that there had been a speech examination. Between these dates all cases where these factors were present were chosen. The writer aimed at obtaining a group where in each case stuttering of some degree occurred. This was thought sufficient to give a representative sample for the purpose of this paper--that of studying the social situation in the lives of stuttering children. That the cases were "full service" and had had speech examinations was a condition imposed in order that the information on each case might be more consistently complete. It was felt that no selection operated as a result that would bias the purpose of the investigation as previously stated.

A schedule was formulated (see appendix) covering information on the speech difficulty, the child's early history, his present history, and the

family situation. This schedule was carried through on each case and the resulting information studied in the light of the purpose of this study.

CHAPTER II

THEORIES ABOUT STUTTERING AND STUTTERERS

The primary impression one receives from a survey of the literature is of the wide diversity of approaches to and theories about stuttering and stutterers. It seems that although the problem has been studied closely by a large number of investigators in the last twenty years, a common synthesis or agreement has yet to be reached among them. A book containing the individual theories and therapies of eighteen American authorities and seven European authorities was compiled in 1943 by Hahn, in which are presented sections edited by each individual.[1] Individual theories give main weight to such diverse approaches as body metabolism, conflict between hemispheres of the brain, or underlying psychoneurotic factors. Undoubtedly from such a diversity a unity will in time result including elements of many theories combined. In fact, some theories at present effect such a unification.

The writer was primarily interested, in the light of the focus of this paper on the personality, social adjustment, and social environment of a group of stutterers, to concentrate in her reading more on the role that these factors were allotted.

Mabel Farrington Gifford, chief of the Bureau for the Correction of Speech Defects and Disorders, Department of Education, in California takes the clear stand that what is wrong with the stammerer is his emotional state. She writes:

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1 Eugene F. Hahn, Stuttering: Significant Theories and Therapies.

> There is nothing wrong physically with the speech apparatus of the stammerer. There is something wrong with his emotional state. When the basis of the emotional condition is understood and corrected, the child will no longer stammer.[2]

And, farther on:

> It is definitely known that stammering in children is a sign of profound emotional disturbance and of a serious lack of social adaptation. It is a symptom of conflict, indicating a child's basic insecurity.[3]

Physical conditions she puts as the precipitating rather than fundamental cause, listing in general (1) shock or illness, or (2) physical conditions that may lead to a feeling of inferiority. Proceeding from the thesis that stammering is a sign of "profound emotional disturbance", her approach is to examine the child's environment for pressures that could create emotional disturbance in the child. Her suggestions about the kind of emotional disturbance do not go further than calling it a sense of insecurity or inner conflict. The areas of a child's environment she suggests examining include a general study of the family circle and conditions outside the home. Is the parental relationship harmonious? What of the parent-child relationship? Is the child being kept dependent by parents waiting on him and doing for him things he should do for himself, thus undermining his self-reliance? Are the parents over-anxious with a constant fear for the child's health and safety, or over-ambitious, pushing and crowding the child. From disorder in the home with no regularity of meals or hours she feels confusion and irritation may result. What of the discipline in the home? Has the child received truthful answers on

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2 Mabel Farrington Gifford, Correcting Nervous Speech Disorders, p. 131.

3 Ibid., p. 133.

sex, suited to his age and type of questions? Is there family conflict with quarrels and sarcastic criticism between members of the family? Is partiality shown among the children, or prodding of one child with praise of another? What is the child's relationships with sibling either as an older or younger child; or as an only child does the household revolve around him? Is there undue emphasis on stammering, so that the child is made more conscious of his impediment? Outside the home, do playmates torment him, or is a teacher impatient or too stern?[4]

Thus would Gifford examine the environment assuming that therein lay factors which caused the "profound emotional disturbance" behind the child's stammer.

Robbins of the Boston Stammerers Institute stated in 1943 that stuttering is one of the many symptoms of certain psychoneuroses, and that it appears most frequently in nervous individuals who inherit a tendency either to stutter or to exhibit other nervous traits.[5] Writing earlier he says that "statistics show that one-half of all stammerers have one or more relatives who have stammered".[6] Robbins, in earlier studies from the physiological angle, felt that there was an underlying physiological cause, as far as was known, which was the sudden rise of blood pressure, causing congestion within the brain. Continuing:

> Back of this is the more fundamental psychological cause, namely, such emotions and states of mind as embarrassment, mental confusion, nervous and mental hurry, over-anxiety, over-eagerness,

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4 Ibid., p. 135.

5 Ibid., p. 83.

6 Samuel D. Robbins, Stammering and Its Treatment, p. 7.

> timidity, self-consciousness, or excessive tension, all of which send blood to the stammerer's brain and aggravate the stammering.[7]

Adler considered the stutterer as "compensating for his feeling of inferiority by demanding attention through inflicting self-punishment in isolating himself to gratify his desire for superiority".[8] Psychoanalytic theory, although not primarily concerned with stuttering, has formulated theories in explanation. The Freudian school considers that the stutterer "suffers from repressed infantile sexuality, stuttering perhaps not being a speech defect, but a fixation of infantile oral eroticism".[9]

Coriat is the principal psychoanalyst who has investigated and written on stammering. In Hahn's 1943 compendium he states: "Stammering is a psychoneurosis, caused by persistence into later life of early pregenital oral nursing, oral sadistic and anal-sadistic components".[10] Earlier in his book, Stammering, A Psychoanalytic Interpretation, Coriat explains farther:

> The individual who has never completely renunciated in adult life the infantile pleasure of nursing, who has not surmounted or sublimated his oral eroticism, . . . becomes the confirmed stammerer.[11]

English and Pearson, psychoanalytical in approach, cite first in considering stammerers the work of Travis and Orton on cerebral dominance,

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7 Ibid., p. 13.

8 Eugene F. Hahn, "A Compendium of Some Theories and Therapies of Stuttering", Quarterly Journal of Speech, 23:391, October, 1937.

9 Ibid., p. 390.

10 Eugene F. Hahn, Stuttering: Significant Theories and Therapies, p. 27.

11 Isador H. Coriat, Stammering: A Psychoanalytic Interpretation, p. 15.

which is discussed farther on in this chapter. Orton and Travis feel that the majority of cases of stuttering arise from a lack of cerebral dominance. English and Pearson advocate that stutterers first be tested to exclude this possibility, but that when these stutterers are excluded, there still remain a large group not fitting this classification. Speech disorders may also be caused, they believe, in line with Coriat, by "emotional conflicts affecting the oral sucking or biting relationship with objects or the oral sucking and oral biting function itself".[12] They report that in most cases of stutterers there has been some curtailment of breast feeding and too early and severe toilet training.[13]

In the July, 1943, American Journal of Orthopsychiatry, Despert makes a preliminary report on a study of fifteen stuttering children treated at the Out-Patient Department of the Payne Whitney Psychiatric Clinic in New York. An analysis of her data shows that not enough emphasis has been placed on the oral level of functioning and the close interrelation of chewing and speaking. The same structures are used to incorporate and take in food as are used to articulate and pour out words. Except for two cases where information was lacking and one case where it was negative, feeding difficulties were present. In the majority of the cases great stress was placed on food by the mother.[14]

The Blantons first go into some explanation of the basis of speech

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12 O. Spurgeon English and Gerald H. J. Pearson, Common Neuroses of Children and Adults, p. 103.

13 Ibid., p. 108.

14 J. Louise Despert, "Stuttering: A Clinical Study", American Journal of Orthopsychiatry, 13:517-524, July, 1943.

to explain their theory of the cause of stuttering in their book, For Stutterers. The child before talking goes through a babble period between three months and one year when he plays with many sounds of language, although they are quite meaningless. During this period the child is slowly learning words; as the process goes on, meaningless sounds are suppressed and also other random sounds such as gurgling and suckling. In the evolution of the nervous system, finally the cortex was developed to control and coordinate all other nerve organizations. Before reaching the cortex all sensory impulses pass through a group of nerve cells called the thalamus. If the control of the cortex over the thalamus is interfered with by fear or anxiety or by emotional fixations, then the primitive patterns of the nervous system assert themselves and interfer with normal activity, especially speech. The Blantons believe that the physical symptoms of stuttering are caused by an emotion that blocks off this control of the cortex over the thalamus and lower nerve centers and allows the primitive patterns which have been repressed to come forth and interfere with the movements of speech.[15]

Thus the Blantons believe that psychological factors are the primary causes of stuttering and that the fear states of the stutterer prevent the cortex from exerting control over the organs used in speech. The cause lies in the emotional conscious and unconscious mind of the stutterer.[16]

The Blantons consider two other theories about stuttering they feel have some validity. The first theory is that learning a second language

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15 Smiley and Margaret Gray Blanton, For Stutterers, pp. 6-13.

16 Ibid., p. 94.

at the same time a first one is being learned is likely to cause stuttering. More than considering the interference of one language with the other in speech, the Blantons question what are the reasons that a child is given two languages. Three reasons occur to them: (1) over-ambitious parents, (2) children in foreign countries, and (3) children of parents speaking natively different languages. In all these cases, they feel, there are many other social factors which would make the adjustment of the children difficult. They class the existence of bilingualism finally, not as a total causative factor, but only as a contributing one. The theory of changing a child from left to right-handedness does seem to them to be a contributing factor.[17]

Turning now to some other approaches, those of Travis and Orton, already mentioned, are considered. In contrast to the investigators just discussed, Orton feels that the emotional and personality factors so striking in adult stutterers are notably absent in childhood. Many early stutterers seen within the first year of their difficulty show no demonstrable deviation in the emotional sphere and present no history of environmental or psychological difficulties which seem at all adequate to explain the disorder.

Orton finds that when classified by the time of onset of the disorder, stutterers fall in two main groups: (1) those who have the speech impediment from the time they begin to talk, that is two to three years of age; (2) others who develop normal and facile speech which continues until the sixth to eighth year, when the stuttering begins. The child in the first

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17 Ibid., pp. 85-86.

critical period between two and three years is just beginning to establish his habits of speech and handedness. Some delay in both the beginning of speech and in the preferential use of either hand is common in the history of these children. The second critical period occurs when the child is just beginning to learn his graphic language, reading and writing, and beginning to intergrate these new unilateral brain functions with his speech which is still in a somewhat formative stage.[18]

When Orton classifies the childhood stutterers on the basis of history and examinations of eyedness and handedness, they fall into four main groups: (1) those where an enforced shift was carried out by parents or nurse from left to right hand; (2) those slow in selecting a master hand; (3) those with a strong family history of stuttering; and (4) those with no history of handedness shift, and none others in the family who stutter. In the majority of this last group, however, disorders of language faculty of other types or the presence of a familial tendency to left-handedness can be found by proper inquiry.[19]

Considering emotional reactions and behavior patterns, Orton believes that with the younger group (those stuttering with their first effort at speech) there is no consistently unusual trend in emotional development. They aren't as a rule over-dependent on their parents or antagonistic to them. They develop the usual interest in social contacts with other children of their own age and are not emotionally unstable except for an

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18 Samuel Torrey Orton, Reading, Writing, and Speech Problems in Children, pp. 122-124.

19 Ibid., p. 125.

occasional explosive outburst as a result of the frustration at their speech efforts. In the older group (those whose speech difficulty occurs between six and eight years) there is usually a history of entirely normal development, physical, emotional and intellectual, up to the critical age and commonly no history of adequate trauma, either physical or psychological to account for the onset of the stutter.[20]

Travis states, as recently as 1943, his theory--in line with Orton--that stuttering is caused by a conflict between the two hemispheres of the brain.[21] This has been his stand in the past. However, a footnote is inserted saying Travis is now in the process of revising some of his earlier concepts on stuttering and that these will no doubt extensively include psychogenetic disturbances as a cause of stuttering. Dr. Robbins, head of the Boston Stammerers Institute told the writer of this paper in April, 1944, that Travis since publishing any material had changed over to the psychoanalytic theory about stammering.

Writing further in 1943, Travis gives as secondary causes of stammering such psychological factors as fear, emotional shock, exhaustion, self-consciousness and feelings of inferiority. But psychological causes, he stated then, require a neurological basis for explanation.[22]

Two individualized approaches are made by West and Swift. West, at the University of Wisconsin, has done biochemical analyses of the blood of stutterers and non-stutterers. He concludes that stuttering is an out-

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20 Ibid., pp. 139-140.

21 Eugene F. Hahn, Stuttering: Significant Theories and Therapies, p. 100.

22 Ibid., p. 102.

ward manifestation of a type of body metabolism that differs from that of the non-stutterer. He feels there is danger in the clinician's assuming that all stuttering results from emotional disturbances, and that this may result in overlooking neuro-physiological difficulty, another important factor.[23] Swift, working in Boston, states he has by experiment found a "deficiency in the visual process" of stutterers as compared with normal speakers. The cause is, then, no subconscious complex, but rather the failure of the conscious function, quickly discovered and easily treated.[24]

Nathanson, in a more inclusive statement about etiology of stuttering, advances a possible explanation as to the wide range of independent theories. The various theories are, he feels, valid only in applicable situations. The exercise of speech summons the finest cortical excitation, and in consequence is subject to interference by minor damage. The intricate speech patterns reflect in their display any of a number of damaging factors. Continuing:

> The generalized disturbance which interferes with the prime control of speech may well be changed-handedness, or rather the conflict of the cortical hemispheres; it may well be fear, "an inhibition which occurs before the speech reflex is securely established", or "social consciousness", "neuroticism", "emotional shock", "anxiety", "unconscious emotional complexes", "weakened visual images", "metabolic disturbances", "biochemical unbalance", --in fact there is as endless a number of specific causes as there are cases in which "the cortex . . . is interfered with in . . . exerting control over the organs used in speech".
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> . . . Somewhere in the chain of speech process is a minoris locus resistentiae which must be built up to cope with what for that particular individual is undue stress. Hence a study of the

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23 Eugene F. Hahn, "A Compendium of Some Theories and Therapies of Stuttering", Quarterly Journal of Speech, 23:393, October, 1937.

24 Eugene F. Hahn, Stuttering: Significant Theories and Therapies, p. 95.

stutterer must include neurologic, psychiatric, general-medical, sociologic, and psychological investigation.[25]

As already stated, this study is made only from one approach, that of studying the social functioning and environmental pressures occurring in the lives of a small group of stuttering children. The case records do not contain, nor would the writer be equipped to handle material on the cases from the diverse points of view that stuttering has been studied. However, the writer believes because of the frequent reference to the importance of the social situation in the life of a stuttering child that a study from the social approach may yield some interesting observations about personality, adjustment, or social environment in the group.

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25 Ibid., pp. 76-77.

CHAPTER III

GENERAL DESCRIPTION OF THE GROUP

Before proceeding to study each case individually and the material thus presented, there is given in this chapter some general information about the group.

As is usual with speech difficulties, the group predominantly is boys, containing twenty boys and five girls.

The group when the cases were referred varied in ages from the youngest, age two years eight months, to the oldest, fourteen years seven months of age. Between these two extremes is a fairly even distribution, as shown in Table I. The mean age is seven years ten months.

TABLE I

CHRONOLOGICAL AGE OF GROUP WHEN REFERRED*

Age	No. of Cases
2	1
3	3
4	2
5	2
6	4
7	1
8	5
9	1
10	0
11	2
12	2
13	1
14	1
Total	25

*Age at last birthday

The age of onset of the stammer did not fall exactly where Orton found

it,[1] between the ages of two to three years, or six to eight years, although the data show some tendency that way. In one case no information was available on this. In the other twenty-four, twenty cases had begun to stutter before the age of eight. Six cases began their stuttering between two and three years, nine cases between fine and eight years. (See Table II)

TABLE II

AGE AT ONSET OF THE STAMMER*

Age	No. of cases
2	6
3	3
4	3
5	5
6	2
7	2
8	1
9	0
10	1
11	1
Unknown	1
Total	25

*Age at last birthday

The length of time that the children had had their stutter when this study was made is pertinent. Although the case material was not precisely exact on this point, it was possible to assign lengths of time roughly in years to all cases except the one where onset of the stutter was unknown. This material is shown in Table III. This Table shows that ten of the children had come to clinic and were studied before they had stuttered more than a year. In fourteen cases the stuttering had not existed for

1 See page 12 supra.

more than two years.

TABLE III

LENGTH OF TIME CHILDREN HAD STUTTERED

No. of Years*	No. of Cases
0 - 1	10
1 - 2	4
2 - 3	1
3 - 4	3
4 - 5	5
Longer	1
Unknown	1
Total	25

*Each interval is inclusive of higher figure

The group represented for intelligence, as tested chiefly by the Stanford Binet intelligence test, an average group. The I.Q. distribution of the group is given in Table IV for the twenty-three cases receiving the Stanford Binet test. Two pre-school children, tested instead by the Merrill-Palmer test, were described as "of at least average intelligence" and "high average, possibly superior intelligence", respectively. The average I.Q. of the group, excluding the two children tested by the Merrill-Palmer test, is 101. In only two cases did the I.Q. fall above 120, in only one below 80.

TABLE IV

I. Q. DISTRIBUTION OF TWENTY-THREE CASES

I.Q.	No. of Cases
70 - 79	1
80 - 89	6
90 - 99	4
100 - 109	6
110 - 119	4
120 - 129	1
130 - 139	0
140 - 149	1
Total	23

The school placement of the group is shown in Table V. Five of the children did not yet attend grade school. Eleven children were in either grade one or grade two.

TABLE V

SCHOOL PLACEMENT OF GROUP

Grade	No. of Cases
Pre-school	4
Kindergarten	1
1	6
2	5
3	3
4	0
5	2
6	2
7	0
8	2
Total	25

The general social background of the group may be judged to some extent by the occupations of the fathers. Jobs of the fathers were divided roughly into three categories including (1) trained or administrative jobs, and (2) salesman, clerical, or other service jobs, and (3) laborers or factory workers. Trained or administrative jobs included, for example, lawyer, engineer, or store manager. Clerical, salesmen, or service jobs included fireman, postman, or bartender. Table VI shows this distribution.

TABLE VI

OCCUPATIONS OF FATHERS

Kind of Occupation	No. of Cases
Trained or administrative	8
Clerical, salesman, or service	9
Laboring or factory work	6
Unknown	2
Total	25

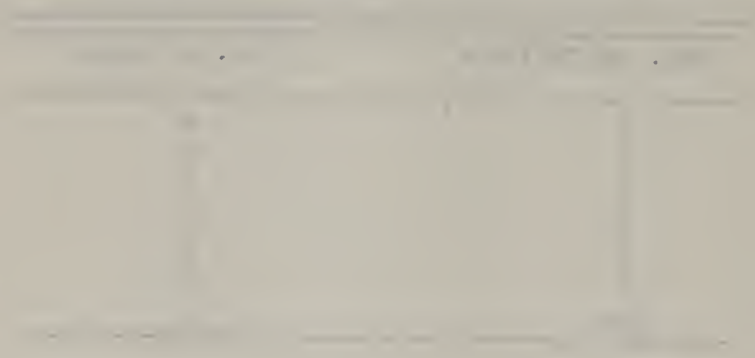
The importance of the financial situation in a family varies very much of course with the attitudes that the family has to this situation. Summing objective fact, the majority of the group had never received aid (19 cases), five families had received aid in the past, and two were receiving aid when studied.

The number of children in a family was on the average between two and three. Four children were only children.

TABLE VII

NUMBER OF CHILDREN IN TWENTY-FIVE FAMILIES

No. of Children	No. of Cases
1	4
2	8
3	8
4	0
5	1
6	3
More	1



CHAPTER IV

CASE PRESENTATIONS

The purpose of these write-ups is to consider the case material on the child's personality and adjustment, the role of the speech defect in this, and the environmental personalities and conditions. Remarks after each case are made from the point of view of high-lighting the various facets of the adverse social adjustment of the child, including the role that the speech defect plays in this, as well as showing the adverse environmental factors.

Material in the cases about factors thought by some to contribute to or underlie stuttering, specifically, hearing two languages, enforced hand-conversion, and the presence of a speech defect in a relative will be considered in the following chapter.

Case 1

L., age five years eight months when referred to clinic, began stammering three weeks before coming to clinic. He has always spoken an infantile unintelligible speech, and is still sometimes unintelligible, leaving out syllables and substituting sounds.

L. is an attractive smiling blond boy whose nick-names are "Skippy" and "Happy". There is nothing in his personality to suggest emotional conflict. He is self-reliant and amuses himself well when alone. His favorite game is "cowboys and Indians". He is friendly and generous, with many friends.

In grade one at school he is doing good average work. The teacher reported him as the happiest boy in school, a leader in his group, and full of ideas. He has learned to say words at school and is beginning to read. But because of his stutter, L. is not being given a speaking part in a school circus, as the teacher feels the excitement and anxiety might affect his speech adversely.

Mother is a stolid, complacent woman with good practical judgment, who is interested in doing the best for her children. She is concerned but not over-anxious about patient's speech. Mother is easy-going and patient; an outside interest includes

activity in church socials. Father is an affectionate, quiet type, easy-going and in good health. Both parents are interested in all the children, and there seem to be no conflicts or jealousies in the family. Father never strikes the children and leaves discipline to mother; the children abide by what mother says. L. is the fourth of six children.

In the evidence present about this boy, there seems to be a good adjustment of the child, although speech is affecting his school life, and no adverse factors evident which might contribute to the speech defect.

Case 2

J., almost six years of age, began stuttering one and one-half years ago. With the psychiatrist at clinic he stammered so severely that sometimes he could not say a complete word, but became breathless with a tremulous voice. Sometimes he opens his mouth and cannot talk at all.

Mother believes that J. is nervous as she is. He is extremely nervous when listening to the radio. When reading an exciting story, he will vomit. At night patient grinds his teeth. He picks his cuticle, and six months ago his eyes twitched. At clinic he gave the impression of being a rather diffident, mild-mannered boy. He felt he could have done better on the psychological examination if he had not been watched.

Most of the time, J.'s playmates are boys twelve to thirteen years of age. He does not play with children his own age as he feels they play "sissy games"; however, mother feels the older boys only play with J. because he has so many toys. These boys make fun of J.'s stuttering and call him all kinds of names because of it.

In school in grade one, patient is in the upper third of his class, an A student. His effort and concentration are good, and he volunteers for reading, with which he has no difficulty. He likes school and his teacher. This case was, however, referred by the school which reported that J.'s stammering was constant and severe to the point of where it was embarrassing his school work.

Since J.'s birth, mother has become more nervous and worried than before because of his ill-health. J. was a premature seven months baby and in a hospital his first two months of life. Until two years ago he had sick spells caused by an upset stomach, and a very poor appetite. In the last year his resistance has been good. J. depends on mother for dressing and other services. Mother talks of her nervousness and is slightly high-strung.

Father, a postman, is very interested in the family. Parents work together in discipline. Affection is shown between all

members of the family. There is one sister, a little more than one year younger than J.; J. and she are very fond of one another.

Here is a child who is showing several symptoms of nervousness and excitability--picking his cuticle, grinding his teeth in his sleep and vomiting with excitement over reading. Until two years ago, he had a very poor appetite. His adjustment with friends is poor, in that his group is much older than he, and he is mocked and called names by them for his stammering. Although he stammers badly in school, his school work and behavior is satisfactory. Mother is a high-strung individual who is over-solicitous about J.'s health, although this is now good.

Case 3

R., age six and one-half, is a mild stutterer, and has always mispronounced a number of words. With the psychiatrist, he hesitated when speaking, which did not seem a true blocking, but as though he feared stumbling. In spite of R.'s infantile substitution of sounds, his language is quite understandable.

R. gives the impression of being an immature repressed youngster. He is timid and easily frightened, a decided follower and not too self-reliant. At clinic when he first came, he was very shy and ill at ease, and sat quietly, clinging to his mother. He does not fight and is not stubborn. Mother remarked that patient's two brothers seemed much smarter and "to pick up quicker", that patient was submissive and more clinging than they. R. did not stop wetting the bed until four years of age, and still occasionally wets if he has a cold.

R. has few children to play with, and mother feels that children mock him because of his speech difficulty.

Patient, with an I.Q. of 86, is in the first grade and not doing very well. Although his behavior is good, he is slow at grasping the work. The school has recommended his exclusion from school for one year so he would have a higher mental age. At present he is unable to do first grade work with the intelligence shown.

Mother feels that she has made R. dependent. Because of the crowded conditions in the home, it is easier to do everything for him. She is extremely solicitous and over-protective. Her reaction to clinic's recommendation that patient repeat grade one was one of worry of how R. would take it. She cried as she

told of her belief that patient was so different from other children, and talked of the way he was teased and was socially immature and dependent. She seems to feel the whole difficulty revolves around R.'s speech, and thinks of him as peculiar.

There is continual quarreling in this home and hatred for the maternal grandfather, the old-world type, who attempts to domineer the household. Disciplining of patient is done by the parents with interference from the grandfather who is always taking an opposite stand.

Patient is the oldest of three boys. He gives in to these two younger brothers, letting them have their way.

Mother is an unstable depressed person. She left school after two years of high school because she was taking it too seriously and becoming a "nervous wreck". Mother hates maternal grandfather worse than she has ever hated anyone although she feels she cannot leave him at present. Grandfather is alcoholic as well as being very selfish and almost sadistic to those around him. Father is described by mother as a good husband and father.

This child, immature and repressed, shows poor adjustment almost totally. He still has occasional enuresis. He has few friends, is doing even more poorly in school than his I.Q. would seem to warrant, and has a dependent relationship to his over-solicitous mother. There is conflict over discipline. Evidence indicates that his speech difficulty plays an adverse role in his adjustment with friends. His mother's worry about him centers in part around his speech trouble. His mother is a depressed, worried person, and the marriage situation is harassed by the presence of the grandfather.

Case 4

W., almost four and one-half years, has stuttered since last year. This stutter shows as some hesitation and is accompanied by infantile speech which W. has always had.

W., a stubborn child and hard to manage, is inclined to fret and feel cranky if he can't have his own way. He is aggressive and a show-off, with frequent temper tantrums. He demands a great deal of attention. He is a very fussy eater and pampered with food he likes. Patient sucks his thumb as well as chewing his hand. When he is on the toilet he masturbates. W. has difficulty in getting to sleep.

W. entered a day nursery when under two years of age, and has in the last year been attending kindergarten. The teacher felt he was immature when he entered kindergarten, but had adapted quickly.

W. is popular with other children and makes friends quickly. He likes other children. He does not start quarrels, but will defend himself.

Mother, who works, usually dresses and feeds patient in the morning as she cannot spare the time to wait for him. Mother's method of managing W. is to coax, as she cannot bear to strike him. W. takes advantage of this. Parents openly disagree on discipline and are critical of each other. Father constantly complains to the school of mother's inability to handle patient. Father is more indulgent than mother, but when he refuses, he is definite and W. obeys. Mother will interfere in front of patient when father is punishing him to try to stop it. W. goes from one parent to another. W. is an only child.

Mother had a nervous breakdown before her marriage and was sent away to rest for two months. She now works as a machine stitcher and is underweight, rundown and nervous. She is irritable and impatient. Father is a lawyer, but barely pays for his office with his practice. He also works for the WPA. Parents are in continual disagreement, chiefly regarding W.

This child shows immature and poorly adjusted behavior of an aggressive sort. The background and rise of this stand strikingly clear when the parental attitudes to and management of W. are examined. Mother is inconsistent and indulgent. The parents in open disagreement between themselves and in front of patient give him opportunity to appeal successfully from one to the other. Mother, in run-down health, is nervous and irritable. The marriage is far from harmonious.

Case 5

J., almost nine and one-half years of age, talked fairly well until he started school when his stuttering began. He showed a rather severe stutter with the psychiatrist.

J. is a sociable and poised boy, friendly at clinic. He is cooperative around the house, willing to go on errands or help with the dishes. He does not have a bad temper, although he is occasionally stubborn.

Children like J., and he has a lot of friends. He is sociable and adjusts well with children, although he likes to be boss.

J., who repeated grade one, is now in grade three at school

He receives fair marks now. His clinic I.Q. was 112. He used to be stubborn in school, but this has improved. J. attributes his poor school work to his speech. The school, which referred this case, said J. stutters so badly, it is painful for all concerned.

Mother works in a mill when she can get work. Father, too, is a mill worker, with intermittent employment. Parents agree and share in the discipline. They use a strap or sometimes make the children stay in the house after school or go to bed early. J. is the second of three children, having an older brother age ten, and a younger sister age eight.

From the evidence available, this boy appears to be a mature adjusted child, with no other problems than his rather severe stutter. Nothing appears of maladjustment in the home or between the parents. The stutter may be causing J. to get lower school grades than he would otherwise; clearly the difficulty is disturbing the school.

Case 6

N., almost nine years of age, began to s tutter about a year ago. This stuttering is not marked.

N. was shy and scared at clinic, although at home is successfully persistent and disobedient with his mother. He is usually rather shy and not very sociable.

He does not eat much, and is finicky about his food. Mother remarked that because of his light eating it is necessary to force him all the time; she is worried about his not having a bigger appetite.

N. plays with many children in the neighborhood and adjusts well. He is well liked.

In grade three when the case was opened, he receives fair marks at school and is no behavior problem. He has never stayed back any grades.

N., the only boy in the family and youngest child, sleeps with his mother in a double bed. Mother states they have no room or money for another bed. Mother, who supports the family with irregular work as a mill-worker, is usually away from the home all day. The children do much as they please, giving mother a great deal of trouble. Mother feels patient will not obey her and that she can do nothing with him. During the worker's visit, N. had to be sent from the room many times, and then was found in the hall listening at the door. Father has epilepsy and has been in a state hospital for six years. Before his commitment he threatened to kill the family. Mother feels patient was afraid of him as father used to roll his eyes around and make all sorts of maneuvers which frightened patient. The disciplining of the children is done by mother; she used to use a strap, but now

punches them with her hand as the children hide the strap. N. is the youngest of six children, all girls, but only two others are at home, the next oldest child, a girl age 13, and an older sister, twenty-four years of age.

Mother is cooperative and pleasant but rather ignorant. She is so harassed by financial difficulties that she has little time for her children. She looks completely worn out mentally and physically. The house was very dirty and badly in need of repair.

This child, although rather shy and easily frightened, at home is out of the control of his mother. Youngest child and only son, he is, at almost nine years of age, sleeping with his mother. Mother is over-indulgent, letting him have his way. The father, hospitalized for epilepsy for six years, may well have made an upsetting frightening impression on N. with bizarre behavior before being hospitalized. Mother, managing the finances on irregular work, is exhausted and has little time for careful attention to her children.

Case 7

R., almost three and one-half years old, was talking well by two years and did not stutter until he recovered from whooping cough just before age three. Along with the stutter he has some infantile speech.

R. is stubborn and difficult to manage, whining and fretting for what he wants. At clinic he refused to separate from his mother and had a tantrum even when mother was with him in the psychologist's room. At clinic R. was negativistic and defiant to overtures made. He usually insists on mother's taking his clothes off and cannot dress himself. R. has a poor appetite, is very dawdling, and insists on being fed. He has occasional night terrors.

In the neighborhood there are no children R.'s age, so he plays mostly with his brother and his brother's friends. He is a scrapper, but not inclined to start scraps. R. does not go to a nursery school.

Mother has catered to R. and done everything for him as she considered him a delicate baby. R. has very serious colds constantly, although these have been better since his tonsils and adenoids operation. Mother mostly coaxes the children and is apt to give in when they are too determined. R. has one five and one-half year old brother who is jealous of patient and the attention he receives from

his parents. R. enjoys his baby position and stages a temper tantrum at clinic when his brother went in to see the psychiatrist. There is some teasing between the brothers.

Mother, a sociable person, seemed emotionally healthy to the worker. Father is an excellent mixer, well liked and charming. Formerly with his own cleaning business, he is now selling electrical goods. Father spends his time off with the family, taking them in the car or teaching the children games. Father is close to paternal grandmother, but mother's wishes are given preference.

Here, if only three and one-half years old, is an immature stubborn child, showing temper tantrums, and forcing his mother to cater to him in feeding and dressing. The mother had indulged and catered to him as she considered him delicate, but with both children she is a lax disciplinarian, coaxing and giving in to them. There is much rivalry and jealousy between patient and his brother.

Case 8

L., age three years seven months, has a slight stammer which began three months ago. She speaks fairly clearly but tries to talk fast. The psychologist at clinic noted no stammering in the entire test. The speech difficulty seemed so slight that it was thought unwise to undertake speech training.

Mother thinks patient is much quicker than her older sister. She is clever with her hands. She tries to dress herself and is anxious to learn grownup things. L. is very stubborn and has a will of her own. At clinic she had a violent temper tantrum when her mother went into the psychiatrist's office and insisted on her mother's staying with her during her psychological test. L. feeds herself but is rather fussy about vegetables and apt to copy her sister's food-capriciousness. If patient is not taken up at night she wets the bed.

L. has no playmates and is in a group only of her nine year old sister's friends. She attends no nursery school.

L. refuses to be left by mother with any of the neighbors, although she will occasionally stay with her grandmother. She demands a fresh dress every morning, and mother gives in to her. She doesn't care to play with toys, but wants to be with her mother all day doing what she does. Mother's discipline is lax; she lets the children override her and then has to be violent to control them when they are out of hand. Mother has to lie down with patient for nap. Mother evidently fears father's criticism of the children, especially if they disturb him at night. When mother began picking patient up at

night, patient cried and fussed and did not want to go back to sleep. Mother finally spanked her which upset father, so mother has been inconsistent with this training.

L. is devoted to her one sister and does not seem jealous of her.

Mother is intelligent and capable, but takes her home life too conscientiously and is too tied down by her children. She is very nervous and seemed extremely agitated and high-strung; she admitted the children upset her very much. Father is well and easy-going. He does not much care for social life but works long hours and reads when home. There is no indication of any marital discord. Both are interested in the home and working hard to bring up their children.

Here is a child manifesting very successful temper tantrums and stubbornness, as well as showing food-capriciousness and badly established bladder control at night. The mother with her continual giving into the child's wishes and will may be described as over-indulgent. The disciplining is inconsistent, suffering from the mother's laxness and the father's and mother's lack of working together. Mother is high-strung and not well adjusted to home life.

Case 9

D., almost seven and one-half years, has been noticed to stutter ever since putting words together. The psychiatrist noted words repeated several times in sentences as well as a definite hesitancy in speech. With the psychologist patient showed only an almost imperceptible hesitation or long breath before speaking.

D. does not seem nervous. He was quiet, alert, and well-mannered at clinic and seemed poised. He is dependable and responsible. In infancy he sucked his thumb for two to three months. Since starting school, D. has begun nail biting. D. sometimes has to be coaxed about eating and has a small capacity.

Patient is cautious about making social contacts and feels situations out before he becomes friendly, but he is not really shy. The only child in the neighborhood is an extreme behavior problem, so that mother's arrangements for him to play with other children are somewhat artificial. With this limited opportunity to play with other children, he seems to have adjusted well to them, and is a leader in a group, displaying considerable initiative.

Patient's teacher feels he is an alert youngster with a good background. Occasionally he plays or daydreams in school, but usually he gets his work done. He is well-behaved, mixes well in the room

and seems to be popular. He has never shown any sign of being excitable or nervous except when starting to speak. D. is inclined to be self-conscious about reading aloud because of his speech difficulty but volunteers to recite.

At home patient has regular chores around the house which he does without being reminded. He is always reasonable and adaptable about orders or discipline. The family enjoys reading aloud together and do so a great deal. Parents take the children on trips, such as to museums. Mother, a conscientious person, is unusually understanding about patient's problems. Father and mother cooperate in handling the children and do it unusually well. If they disagree, they discuss it afterwards. D. understands the rules and why he is punished. There is one adopted sister about D.'s age. He was an only child until this girl was adopted three years ago. D. was very anxious for the family to adopt her, enjoys playing with her, and never seems jealous. She is in his room at school, which pleases him.

Mother is quiet and rather shy, but alert and intelligent. D.'s kindergarten was financed by mother's assisting there. Father is an engineer and a superintendent in a Sunday school, where mother also teaches. Father and mother get along well on managing the children and things around the house.

D. is apparently adjusting well in his various relationships although he has bitten his nails since starting school and shows some food-capriciousness. With friends and in school he gets along satisfactorily even if the stuttering interferes somewhat with his reading in school making him self-conscious. The parents seem unusually cooperative, with understanding of their children and a united home life.

Case 10

R. was just under five years of age when first referred to clinic. About two years before, he had suddenly developed a hesitation in starting to talk and also began mispronouncing words. At the first referral his speech defect of stammering and infantile pronunciation was marked. At this first referral mother did not wish to bother to take patient to the more distant clinic where speech lessons were available, so the case was closed. Two years later, mother returned with patient for speech lessons. At this second referral, patient stuttered by repeating the entire initial word as well as the initial syllable or consonant. At times he would repeat the first word of a sentence over and over again and not be able to get any farther.

When first to clinic at age five, R. was described as immature, rather effeminate, and extremely dependent on mother. He was nervous and cried easily, becoming easily upset. He would cry to get his own way. R. was negativistic and had temper outbreaks when mother tried to force him to do something. R. has always had a poor appetite and sat at the table longer than the rest of the family until he finished his plate. At the age of seven he still had to be coaxed through meals. At the age of five patient still had occasional enuresis. His nails were bitten at both five and seven years of age.

At age five there were no boys R.'s age in the neighborhood so that he usually played by himself. When he was with older children he was teased a good deal and did not like it, being apt to cry and whine. Two years later he was reported as playing well with children his own age, but apt to get in a temper if he lost.

The second referral was made by the school where R., in grade two, was doing well, although his speech defect was making satisfactory progress difficult.

Mother at the first clinic contact treated R. as one would a younger child; R.'s response being resistive and combative. At clinic she coaxed and bribed him, and most of the things she asked him to do were completely ignored or else resisted. The social worker felt that mother was probably trying to make up to R. her own unhappy childhood by indulging him, and that she was apparently unaware of his dependence, immaturity and dominance of the household with his temper tantrums. Because mother was anxious to overcome patient's crying when with other children, she would interfere to find out what was causing the difficulty. R., with one sister five years older than he, has had more attention and been more indulged than she. Parents do not interfere with each other on discipline.

Mother seemed immature, lacking in poise and self-confidence, willing to let someone else take the lead, even patient. She had an insecure unhappy childhood, having moved about often after maternal grandmother's death when mother was twelve. Father, a store manager for fifteen years, is sociable, enjoys going out, and enjoys the children.

This child is an immature, spoiled boy, with many temper tantrums and much resistance to his mother, some food-capriciousness, enuresis, and nail-biting. At neither age five or seven does he get along very well with other children. Although patient is doing well at school, his speech is hindering his progress. His mother, immature and unconfident, is giving in to R. in his spoiled behavior, and both parents are indulging him more than his older sister.

Case 11

P., an eight year old boy, talked clearly until three or four years old when he began stuttering. P. said he had been brought to clinic because something was wrong with his throat, then became self-conscious and made brief replies to prevent stammering, answering in monosyllables if possible. P. has spasms while trying to talk.

P. is a quiet boy who rarely talks, so that it is difficult to know what he is thinking. He is immature and cries and whines a great deal if things don't go his way. He cries very easily. He was tearful and apprehensive about having a psychological test at clinic and refused to leave his mother in the waiting room. In simple situations such as crowded streets he is fearful. P. has nocturnal enuresis, and soiling had continued until attending clinic when some improvement occurred. When P. was just over two years of age, he masturbated when in bed. Two years ago, there was probably some sex experience with a boy patient's age; at least patient was present. P. talks quite a bit during his sleep, numbles and is restless.

P. gets along pretty well with other children. He used to belong to a cub scout troop before it broke up and enjoys anything of that sort.

P., with an I.Q. of 83, entered grade one when six years of age and repeated the year. Now in grade two, he is not very fond of school, although he likes this year's teacher better than last year's. When the teacher calls on P. in school, he doubles over.

Mother, who was not married to father until six months after patient's birth, worries about the community attitude to her and patient. She fears someone will tell P. he is illegitimate. Mother used to whip patient before coming to clinic, particularly for soiling, but found that it did no good. Father is usually very easy-going and leaves all the discipline to mother, taking no interest in the children's problems or training. P. has one brother, age three and one-half, of whom he is at times jealous, accusing his parents of giving him more. Father definitely favors this younger child who is more affectionate and demonstrative.

P. has no preference between his parents but cares much more for maternal grandparents who have cared for him intermittently when mother worked. They favor patient a great deal, so that mother cannot handle him when he returns from a visit there. Parents try to limit P.'s visits there, so now he goes only once a week.

Mother is a very unhappy disturbed person. She considers herself nervous, "flies off the handle" easily and is bothered by noise. She has very few outside interests. Mother has been worried since marriage about finances, off and on. Father's employment has been irregular, and the family has had public welfare relief. Father is so quiet that mother finds him not much fun to have around. Apparently he simply provides for mother, never taking her out. Mother feels shut out from his life and is very unhappy about her

marriage. Parents were not married until after patient's birth because father at first refused, accusing mother of promiscuity.

This immature quiet child shows a number of symptoms of disturbance. He has enuresis and soils, as well as being restless and talking in his sleep. Formerly he masturbated and within two years had some sex experience with a boy in the neighborhood. He is apprehensive and cries easily. Although, from the evidence, he gets along with friends and in school, his speech defect bothers him when he is called on in school. The mother-child relationship is interfered with by grandparents; father definitely favors patient's younger brother. Mother is an unhappy disturbed person with many emotional problems, and the marriage does not seem to be at all a congenial one. Patient is somewhat jealous of his younger brother.

Case 12

W., eleven and one-half years old, talked plainly until he was about six or seven years old. His stammering on consonants is marked, with simultaneous waving of his elbow. His mouth locks wide open in a complete block of speech.

W. is very sensitive and easily upset, crying easily over nothing. He is excitable and "gets all nerved up" if things don't go well. W. is pleasant and good-natured usually, but is inclined at times to be fault-finding and quarrelsome. Family believes that W.'s restlessness, fretfulness and fault-finding are the result of his prolonged physical illness. W. has had bronchial pneumonia every two years since he was six months old. At the age of nine he was absent from school six months with a chronic appendicitis. One year prior to the parents' separation when W. was eight years old, he became excitable and sensitive and began biting his nails, which he has done since. When a baby patient sucked his thumb but stopped doing this himself. His sleeping is rather restless at night.

W. gets along well with other boys; he likes football and other active sports and likes to be out of doors.

Now in grade five, W. likes school although occasionally he comes home crying when the children have picked on him. His marks and behavior are good. The teacher felt patient showed no hesitation or embarrassment about reciting in spite of his speech difficulty.

W. is inclined to be defiant and disobedient and wants his way in most situations. He has not had the benefit of consistent and

judicious training as mother felt that patient was too weak to make regular training advisable. W. has not had the discipline the other children had. She feels she is a weak disciplinarian and never has the courage of her convictions nor the ability to hold out against patient.

The other two children in the family, younger than W., are a brother ten years, and a sister almost nine. The children do not get along with each other but all tease and annoy one another. W. starts fights with his younger sibling and cannot defend himself. He will then call on his mother for help, who in the past has taken sides with him.

Mother was married ten years when father divorced her. Before the divorce she was calm, easy-going, and light-hearted, but since then she has been inclined to be nervous and worrisome. Father was a "home body" before the divorce, interested in the children, reliable, and good to mother. It was an unexpected shock when father asked for a divorce, and there was no warning of the difficulty. He left three years ago to marry another woman.

Maternal grandfather, who now lives with the family, likes the children and gets along with them. He seemed an interested, well-intentioned person.

Here is a sensitive excitable boy, who along with his disobedience shows traces of being dependent and immature. This is accompanied not illogically, by crying easily and nailbiting. This boy's speech difficulty does not seem to bother his school work or adjustment. He does not get along with his siblings, but is into fights and teasing with them. Mother, since her divorce inclined to be nervous and worrisome, has been over-protective with patient, standing up for him against his siblings and not disciplining him consistently or firmly, partly because of his intermittent poor health.

Case 13

B., almost eight and one-half years old, began stammering when four and one-half years of age, following a throat illness when he lost his speech entirely for several weeks. With the psychiatrist B. talked with ease at first, but in a few minutes showed a marked stammer. At times he became so tense it was impossible to get any words out; his eyes would roll upward and he would show a definite picture of distress.

B. is very stubborn if made to do things and will argue and be persistent about getting his own way. He cries easily, and if crossed has a temper tantrum of crying. After being breast fed for two months,

patient refused the breast and was put on the bottle until one year old. He would take little from the bottle; mother stated, "It was his will against mine." During infancy he had continual nutritional difficulty and did not eat properly until four years of age. B. sucked his thumb until he went to school. He bites his nails spasmodically. About once a week B. has night terrors when he gets up and walks about the room. He has cried out frequently in his sleep since his tonsils and adenoids operation when five years old.

B. does not like groups of children very well and plays more by himself than with a group. He states it is because he has so many interests that they aren't interested in. If the group isn't doing what he likes, he goes off and plays by himself. B. cannot defend himself and is chided by other children. Mother feels that the other children often tire of having him around because of his speech.

In grade three at school, patient is very fidgity and nervous, chewing his pencil constantly. His teacher reported he did not pay much attention and was a dreamer. He is inclined to be the class cut-up and disobedient. B.'s reading is handicapped as he takes so long to get started and gets so excited and aggravated about it. Because the other children get so anxious and disturbed, the teacher avoids having him read as much as he should.

Mother feels that patient would have better stamina if she had not become pregnant two months after a miscarriage. She feels every illness B. has had he has been quite ill with; he is underweight and does not gain easily. Mother worries much about B. and his problems. She is defensive and protective so that he has not had to meet difficult situations alone. She alibis for him as a "different child." The previous year mother felt the school was unfair and reprimanded them. When patient cries in his sleep, mother runs to his room, talks to him and pets him. B. likes to have mother hold him on her lap and baby him. He wants his mother to stand by the window and wave until he is out of sight when going to school. Mother feels that over-coming B.'s speech defect is the most important thing in the world to her.

Father has little to do with the children's discipline. He is inclined to yell at them; mother interferes when father's discipline is harsh. Father thinks the children should respond more quickly to discipline than they do.

The other children are an older brother, age twelve, and a younger sister age four. B. never plays with his older brother who has his own social group and does not include patient. These two don't get on particularly well; they have different interests and the brother feels that B. will not cooperate with him.

Mother is inclined to be nervous lately, worrying much about B. She is "on the go" socially, likes clubs, and is president of a woman's club. Father tries to help with the children, but this is not natural for him. Parents go out together occasionally, but for the most part their interests are separate. There is not good cooperation between them.

This boy, stubborn, yet overly affectionate with his mother, was a feeding problem until four years old, sucked his thumb until going to school, and bites his nails spasmodically. He cries easily, has temper tantrums, and has disturbed sleep with night terrors and crying. He does not get along well with groups of children who evidently are annoyed by his speech. In school he misbehaves and daydreams; his speech interferes very seriously with his reciting. Mother, guilty about his birth, is over-solicitous and very obviously babies him. She is overly concerned about overcoming his speech defect. Parents do not agree on discipline and interfere with each other. Patient does not get along well with his brother. Mother is nervous and worrying. There is poor cooperation between parents.

Case 14

K., six and one-half years old, has been stammering for the last year or so. He has never spoken clearly, and his speech is characterized by baby talk as well as the stammering and hesitation. It is difficult to understand what he says. While talking he always shakes all over and moves his feet. His speech defect gave the appearance of being a central nervous system impairment, rather than a defect of functional origin.

Mother considers K. alert and observant. He does not have temper outbreaks and is not stubborn or persistent in getting his own way. He is usually good-natured, although a little inclined to tease. He is independent, willing, and fairly responsible. K. never seems self-conscious about his speech difficulty. Although in the psychological test there were many involuntary movements of the hands, arms, and shoulders, patient seemed to be able to bring the large muscles into control sufficiently for writing and manipulation. K. is food-capricious about food he doesn't like, so that mother has to feed him these things. He wet the bed until he was over four years old.

K. is mature and wants to be with boys his own age. When with other children he gets along well, playing congenially.

In grade one, patient likes school, talking a lot about it at home. His teacher reported he seemed interested in all his school work and behaved well. He is doing his work well. His reading does not seem to be handicapped by his speech, which does not embarrass him at all. K. gets along well with the other children. He is,

however, extremely nervous as shown by hyperactivity. Because of poor coordination he cannot do handiwork well.

Mother is emotional and overly interested in this child, and in getting help for his speech. Mother was pregnant with patient during the early stages of the depression and did not wish another child at the time. She felt resentful during the pregnancy which the worker felt perhaps made her more eager and concerned about the boy. Mother feels her solution of patient's occasional food-capriciousness, that of feeding him, is an adequate one. At night patient demands that his bedroom door be left open so the kitchen light will shine in, which is allowed. K. is obedient and requires little disciplining although mother admits she is not overly firm with him. There is no interference from father on discipline, mother doing most of it. Besides K., there is one older brother, eleven and one-half years old, and a baby sister. Patient becomes much annoyed when the other children in the home get noisy. He is a little inclined to be jealous and is particularly anxious to get mother's attention if she is demonstrative with the baby.

Mother has been unable to close the fist of her right hand for the last four to five years. The hand began to be stiff during her pregnancy with patient and has become worse in the last six to seven months. Shortly before coming to clinic she went to a hospital where the diagnosis of "nervous hysteria" was made. Mother has been nervous since the depression, worrying over finances. Father, a steam fitter's helper, has irregular work. The family just manages to get by without public welfare. In the past father has been on various public relief projects. He is calm, easy-going, and enjoys the children and being at home.

This boy, despite his severe speech difficulty, seems adjusted with friends and in school. However, he wet his bed until fairly late and still is somewhat food-capricious. Mother's relationship with patient can be characterized as somewhat over-solicitous and over-concerned, part of her concern centering around the speech trouble. K. is inclined to be jealous of his younger sister and annoyed by both siblings. Mother, worried for years over finances, has an hysterical conversion symptom of a stiff right hand.

Case 15

A, six years three months old, began stammering six months before coming to clinic. Besides a marked stammer she has very serious infantile speech. With the worker she at first would not talk;

then, starting with stammering, she soon chatted easily. In her stammering she both repeats initial consonants and hesitates, but does not enter into any contortions.

A. was very shy at first at clinic, clinging to her mother and hiding behind her. More retiring than self-assertive, she seemed a little old lady in manner and attitude. A. is stubborn and delays in minding; she does not have temper tantrums but sets up her will by passive resistance. A. wants mother to feed her and is somewhat fussy about her food. Mother has tried ignoring it, but there is still a problem. Patient used to bite her nails.

A. plays outdoors with children in the neighborhood. She is good-natured and usually gives in. One child who is demanding and domineering she quarrels with.

Patient's first grade teacher feels A. would like to run the class and would get out of hand if given too much freedom. A. stammers when she first begins to talk, but gets over this. The teacher thinks patient is very bright and would do much better if she were not handicapped by her speech difficulty.

Mother is a "nervous wreck" over A. and becomes so angry she slaps her. She gets irritable if patient does not obey her every wish. A. is held to high standards. Mother gives the impression that patient was always an annoyance because she so disturbed the whole home routine, especially when a baby. The house is evidently dominated by mother's zeal for housekeeping; mother resents patient's getting anything out of place. Parents never go out together because mother has to remain with A. and put her to bed. At patient's birth, mother dropped bridge club and her old friends. Mother escorts A. to and from school. A. is an only child.

Mother is a tense, excitable impatient person. A meticulous housekeeper, she can't bear to have anything out of place. With her nervous drive she is exacting of herself and others. For twelve years before marriage, she worked in a telephone company, working up to the position of supervisor. The pressure of work of the job made her nervous. Father has more interests than mother, occupying himself with work and fraternal organizations as well as reading a great deal.

This girl, somewhat shy, is a rather stubborn, resisting child with her mother. She wants mother to feed her. Her school adjustment seems poor, in that she is likely to get out of hand. Her speech trouble is keeping her from doing the much better work the teacher feels she is capable of. The mother's attitude to A. is much too rigid, combining strictness with an excessive limitation of mother's activity for patient. Mother is high-strung and tense.

Case 16

D., age two years eight months, began to stammer two or three weeks before coming to clinic. His speech seemed well established in that he made complete sentences. The stammering fluctuates in severity. With the psychiatrist there was no evidence of it. With the psychologist it was noticed but not as particularly severe.

D. is very persistent and has tantrums when he doesn't have his own way. At clinic he screamed and cried when asked to go to the psychologist, and kicked and screamed all the way to the speech worker. Each one of the six speech lessons patient started with screaming and crying. All the time the worker was in the home, D. cried and whined, which mother said was typical behavior. D. used to be capricious about his food. Maternal grandmother insists upon feeding him, which mother does not want. Mother used to worry about patient if he didn't eat but has stopped now. Grandmother makes a fuss about his not eating. Sometimes D. has only two meals a day, refusing most often his supper. D. used to suck his thumb which mother overcame in three weeks with cardboard cups.

Whenever anything displeases D. when he is with other children, he has the habit of biting them. He plays occasionally with a little boy who lives near although he is apt to bite him. D. does not attend nursery school.

D. undresses himself at night but insists mother do things for him. He will not allow the maid to help him; if he wants help, mother has to do it. D. wants to be where mother is and does not like to be alone at all. When the worker was in the home, mother allowed patient to stay with them the entire time and cry. Mother became pregnant with D.'s sister when D. was five months old and was nervous dealing with him when pregnant. She feels he did not have adequate training at this time.

Maternal grandparents are in the home a great deal and are constantly quarreling with mother about her ideas of child-training, which upsets mother very much. The grandmother even called the pediatrician to complain about mother's handling of D. The grandmother is a typical egocentric neurotic who dominates her own household with her neurotic behavior. Grandmother berates mother for patient's stutter, which is mother's "sensitive spot".

D. is extremely jealous of his sixteen months old sister. If anyone picks her up, someone else must pick him up. He is very selfish, dominating, and teasing with her.

Mother would like to be independent from grandmother, but also has a sense of guilt about it. Mother has peculiar head symptoms which did not clear up even after a gynecological operation. The psychiatrist stated these head symptoms were neurotic. Father is devoted to mother and the children. He never goes out without mother, and they have much fun together. Father is a calm, easy-going person in good health.

Although from a child under three years one does not expect mature behavior,

D. is seen continually manifesting tantrums, allowing help only from his mother, and wishing to be with her continually. D. gets on very poorly with other children as well as his sister. Mother's training of D. in the past was inadequate during her second pregnancy and is now seriously interfered with and negated by the grandparents. Mother, with her undesired dependence on grandmother's opinions, apparently has been made to feel guilty about patient's stutter. Mother herself is showing undue dependence on maternal grandmother as well as physical neurotic symptoms.

Case 17

M., twelve and one-half years of age, had stuttered some at the age of four but got over it. Then in the past two years her stutter returned. She repeats sounds and has spasms in her facial muscles. With the psychologist she stammered very much in reading but not in general conversation or in answering questions.

M. at clinic seemed a responsive friendly child although shy and reticent. Mother feels she is difficult to know and more stubborn and wilful than her other children. She has a violent temper and used to have temper tantrums when younger. When someone hurts her feelings, she will lose her temper and fight. M. will not obey right away; only with a lot of coaxing will she do as she is told. She is particular about her clothes, and of those given the family she wears only what she thinks stylish. Until a year ago, M. was very finicky about her food, but has gotten over this. Until three years ago, she had nocturnal enuresis.

There is one girl patient's own age in the neighborhood with whom she plays and gets along well, apparently. Also she is friendly with two boys who live next door.

M. seems to enjoy school, although she has always been rather slow. In grade six, the school felt she was just getting by into the seventh grade. At clinic her I.Q. was low average, 91. Her adjustment socially seemed to be good. M. will not volunteer any information in school and stammers if urged to recite.

This case was referred partly because of M.'s disobedience, partly because of speech. Mother feels M. is rebellious to discipline. Discipline of the children is mostly threats. Father can discipline more successfully than mother. The parents do not interfere with one another. In this family are ten children, of which patient is the fourth oldest. M. is inclined to be very jealous of what the other children have and feel she doesn't have her share. If mother shows any affection to her younger sister, M. wants affection too. At clinic M. always let her sister, who seemed brighter

and more attractive, take the lead.

The home, a five room house, was in very poor condition. There has never been sufficient money for mother to be without economic worry. The family receives aid from relatives and private charitable organizations at various times. Mother has few activities outside the home, and seemed depressed by the family situation and indadequate funds. Mother has rebelled against having so many children but feels it would be contrary to her religion not to have. Father, general handy man in a mill, is inclined to worry a lot and is somewhat alcoholic. He has a "nerve twitch" and is excitable and impatient.

This girl, although shy and friendly, is a disciplinary problem to her mother. She has a violent temper. Although her school work is low and her stutter interferes with reciting, she is doing passing work and seems to like school. She evidently feels insecure among her siblings, showing jealousy of belongings and affection. In this family is much financial stress and worry, the burden depressing and worrying the mother. The father is somewhat alcoholic, perhaps his way of facing the financial difficulty.

Case 18

M., fourteen years of age, has stuttered intermittently since she started to talk. With the psychiatrist she stuttered very little; with the psychologist there was a hesitancy in her speech, but not frequently.

M. is a shy, but well-balanced girl. She does not cry easily and never shows her feelings. She is obedient, trustworthy and independent, neither aggressive nor submissive. At first at clinic she seemed ill at ease, but was a smiling different person at home. M. is very conscious of her speech defect. She herself asked for speech lesson help. M. bites her nails.

M. plays with children her own age of both sexes, and adjusts well. She belongs to the girl scouts and the YWCA. She is well liked by many friends. She is neither a leader nor a follower.

In the eighth grade at school, her teacher felt she was well able to do the work. She gets average or better grades, and her conduct is good. The teacher had never noticed the speech difficulty. M. has told her mother that often when called on she will say she doesn't know rather than getting up to recite; her grades in oral subjects were much lower than the written work. On the

psychological test given at clinic M. received an I.Q. of 76, giving grounds for thinking that perhaps patient blamed her speech difficulty when she did not know answers.

M. is very frank with her mother and comes to her with all her problems. Patient is affectionate but not demonstrative. Mother is much interested in the children. Father died one and one-half years ago and the family lives with maternal grandparents. Only mother, however, does the disciplining, not allowing grandparents to interfere. There is one brother, age eleven, with whom patient gets on well.

Mother is working as a secretary and learning the oculist business, hoping to go into business for herself. Father, who was a real estate dealer, died of pneumonia.

This girl seems to present a general picture of adjustment, although shy. She is getting along well at home, with friends and in school. She herself is very self-conscious about her speech defect--more than others--although she may be excusing herself in school work on this ground instead of the true reason of being of low intelligence.

Case 19

P., just over six and one-half years, always talked plainly until about one year ago when stammering started. This has become worse since starting school. P. was eager to talk to the psychiatrist but found it difficult because of an outstanding stammer characterized by repeating the initial consonant in every word. With the psychologist he showed only a slight stammer at starting sentences.

At clinic P. was extremely quiet and rather shy. His mother reported he is persistent and argumentative with her. He has a quick temper; in infancy he used to bang his head against the wall in tantrums. P. has a good appetite but is inclined to be capricious about his food; only with a great deal of urging will he eat a small portion of things he does not like. Patient has had a fear of fire since several years ago when he was standing behind a car that caught fire.

P. is shy with other children and frequently complains that they do not like him. He plays chiefly with his younger brother and is ill at ease with other youngsters. He has complained that some older boys tease him and pick on him as he is coming home from school.

P. is now in grade one, likes school very much and does well there. His teacher felt he was unusually dependable, independent and trustworthy. He does very good work although his reading is slow. When he tries to say something there is a marked hesitation

and blocking on the first letters, but no speech defect shows when reading.

Mother argues with P. rather than insisting on obedience. Father thinks they are like a couple of children in these arguments. Mother occasionally spanks but finds it gives no results. Mother, more inclined to be nervous than father, is impatient with the children so she occasionally slaps them in a fit of temper. During the last year with her last pregnancy this was particularly marked.

P. is the oldest of three boys, one two years younger than he, one a seven months baby. P. is easily irritated by his four year old brother who is more alert and articulate. P. has exhibited jealousy because of the younger brother's ability to get attention. If P. is having difficulty in expressing himself, the younger brother will take up the conversation and say what patient is trying and failing to say.

Father has always had steady work and the family a comparatively adequate income. Father has always been well, is extremely calm and easy-going. He is a good father and enjoys playing with the children.

Although shy at clinic P. is rather successfully argumentative and persistant against his mother who is not too firm and has been inclined to be irritable. With friends he gets along poorly and also doesn't get on well with his more articulate brother who will take the conversation from him when he stutters and finish for him. Although he stutters in school, his work and adjustment seem satisfactory. Mother is inclined to be nervous with the children.

Case 20

A., age twelve and one-half, began stuttering three or four years ago. He has always used infantile speech and now speaks explosively with lisping and serious stammering, an extreme speech defect.

A. has always been an independent child. He never wants to go to bed when he should. He attends the movies an average of three times a week, going whenever he desires. A. is a cheerful boy, amiable and anxious to please. Mother stated he used to be very capricious about his food, but now likes everything. He has bitten his nails as long as his mother can remember.

With boys his own age patient is sociable and well-liked. He does not pick quarrels but will stand up for his own rights. Mother believes he has a great many friends but that children tease him because of his speech.

In school A. is repeating grade five and not doing as well as well as last year. At clinic his I.Q. was 84, but it was thought he was using his dull intelligence to its fullest extent. A. doesn't seem interested in trying this year, his teacher felt. With the other children patient seemed popular and has never been made fun of by them.

Mother has always liked A. better than her other children because he is the baby and father died two months after his birth. Mother wants to curtail his going to the movies but finds it difficult. A. does not want to help around the house, and mother has to bribe him by giving him a penny if she wants him to help. The school felt mother's discipline was ineffective; the worker thought mother was quite unable to control patient. Mother appears to expect the school and outside agencies to assume responsibility for A.'s behavior.

The six children in this family range in ages from the oldest, twenty-three, to patient, age twelve. One fifteen year old brother teases patient constantly, getting him very much upset. These two quarrel a great deal. This brother laughs at A.'s speech and tells him to "talk tomorrow".

Mother considers herself a little bit nervous. She gets irritated when the children upset the house where she wants everything nice. She goes out almost none at all. For a long time after father's death the family was supported by mother's aid; now the incomes of the older children support them.

This child, favorite of his mother's, seems to be ineffectively disciplined and controlled by her. A. has a very poor relationship with one brother who constantly teases and irritates him. In school patient is repeating and still doing poorly. A. is teased for his speech by friends as well as his brother although his general adjustment with other children is apparently good. Mother, who gets out of the home almost none, is irritable with the children and somewhat nervous.

Case 21

R., three years three months old, began to stammer when R. was under three years and became worse after a tonsils and adenoids operation a month before coming to clinic. At clinic the stammer seemed slight; R. talked spontaneously and well with the psychiatrist and stammered only slightly with the psychologist.

R. is a good natured, sweet boy and seemed amazingly friendly and poised at clinic. He is obedient and never cries. With the

psychologist he was friendly, alert, and interested. Just lately he has been biting his nails.

R. gets on well with other children, is sociable, and makes friends with everybody. He is well able to defend himself. R. does not attend nursery school.

Mother is high-strung and emotional, worrying that something might happen to the children. Although patient has had no illnesses except colds, mother worries about the health of the children and feels they don't get enough sunlight. Mother herself had never been well until the last few years, having suffered much from arthritis which still bothers her. Mother is very anxious to have help with patient's speech defect and feels that his speech difficulty is serious. Father feels very badly about R.'s speech defect and is very anxious to have something done for it.

Paternal grandparents have lived with the family nine years, and the home is very crowded. Mother administers most of the discipline with R., usually locking him in the bathroom or bedroom. When patient calls to paternal grandmother, she will often let him out. Grandmother insists on indulging the children.

R. has a sister almost two years older than he and a brother, age two. The sister is jealous of both her brothers. R., not often generous with his sister, is generous with his baby brother, although probably a little jealous.

Father is very quiet and rather afraid of having company and meeting people. He is a bartender and changed jobs recently from one which had long hours that mother felt made father nervous. Mother has never had any quarrels with father; she is always the one to make decisions.

This boy seemed friendly and poised at clinic and gets along with other children. He has begun to bite his fingernails recently. The mother, however, seems to be a worrier about the children and over-solicitous; both mother and father are very anxious about patient's stammering. Discipline is interfered with by grandparents who live in the home.

Case 22

J., almost eight and one-half years old, began to stammer when he was four years old. He also lisps, which he has always done, a kind of infantile speech.

J. appears immature and babyish. He is quick-tempered and cries easily if crossed when he will scream, stamp his feet and use swear words. He takes no interest in his personal appearance and takes very little responsibility. He seemed dependent both at home and at clinic. Before he was school age, a much older girl told J. to lie down and then took out his penis. Also, very recently he has

had apparently some sex experience with a man in a general store near. J. was not coming home when he should from school and had been given candy by the man who has this reputation. J. bites his nails.

With other children J. tends to let them walk over him and not stick up for his own rights. He is easily led by other children; if older children tell him to do something, he will do it. If he gets into a fight, he cries very easily. He is shy and does not make friends easily, either with adults or children. There have never been enough boys to play with, and J. would rather play with girls. His interests are somewhat girlish, such as girls' games, and dressing up in his mother's clothes.

Now in grade two after repeating grade one, J. is not doing very good work and may have to repeat again. His spelling is very poor, reading very slow and arithmetic below level. J. will not talk loud enough in school to be understood. He did not used to play well with other children but is doing better now although he is apt to hit them. Patient's clinic I.Q. was 87.

Although J. knows how to dress himself, he is so slow that mother frequently helps him. J. loves to be waited on and mother has always done it "hand and foot". She watches him every step of the time he is outdoors as she is nervous about him. J. has always slept with mother, more or less, and father on a cot. For discipline mother nags a great deal but seldom really punishes. Only at times is he obedient. Father disagrees with mother's discipline and says mother would get better results by talking less and being firmer. J. is more affectionate with father than mother; he loves to sit on his father's lap and kiss him. Father is very much interested in J. and affectionate with him. J. is an only child.

Mother is extremely unhappy in her home. She finds it difficult to adjust to the change in the family's economic level; father, who formerly had an excellent position in another city, is now on PWA. For two years mother and father have not lived as man and wife; mother cannot bear the thought of marital relations. Mother feels she has grown reserved and cold toward father although father is still devoted. She has no interests outside the home at all now. Father is calm and even-tempered and has always been very generous and sympathetic with mother.

Here is a very immature, unassertive child, showing temper tantrums with his mother. He is quick-tempered and cries easily. Shy and submissive with other children, he plays chiefly with girls. In school--much more than his I.Q. would indicate--J. is one year retarded and perhaps to be retarded another year; he does not talk loud enough to be understood. Mother is strikingly over-solicitous with patient, waiting on him and

watching over everything he does. Her discipline is not firm with which approach father disagrees. Mother herself is very unhappy and maladjusted in her marital relationship and upset by financial changes.

Case 23

M., fourteen and one-half years old, has been noticed to stutter in the last three years. At clinic she did not stammer at all with the psychologist and only when first introduced to the psychiatrist.

M. is an attractive small girl, very shy and seeming embarrassed at clinic. Mother stated she is always easily embarrassed. M. seemed very eager to overcome her speech difficulty and very sensitive about it. As a rule she is very calm. M. is reliable and good-natured but will not be imposed on and always stands her own ground. She and her twin sister have certain household duties, which M. never makes a fuss about as she knows she must do.

M. plays with girls her own age from school. She adjusts well with other children and is a leader. She belongs to the girl scouts and to a girls club at the church. M. just received her life saving badge for swimming.

M., now in grade eight, failed grade five when she changed schools on the family's moving from another town. The teacher feels mother pushed patient in school beyond her ability and made her very nervous. Mother told the teacher, "I keep after M. all the time and tell her to study harder; I don't want her to fail again." M., doing good work in all her studies, tries very hard to get all A's and cannot understand why she can't. The teacher does not wish to tell her she does not think she is capable of it. M. becomes confused when reciting and stutters; she never volunteers. Her I.Q. at clinic was 81.

Mother looked very self-conscious when the worker spoke of her pushing M. and said she'd say no more about never failing again. Mother gives the impression of being easily irritated. When the children, during worker's call, were home from school for luncheon, mother talked in a high-pitched voice and was very much irritated when they didn't wait on themselves. M. and her twin sister alternate by weeks in sleeping with mother. Mother babies and pampers M. very much. M. is frank and confidential with mother and always comes home to her to talk things over. Mother tries to assume the responsibility of discipline herself although the older children are apt to try to help her. M. and her twin sister are the youngest of six children.

Mother, a nervous neurotic type, is high-strung although pleasant and sociable. She is in fair health now except for a "falling womb". Father died ten years ago, and the older children are supporting the family with fairly steady work. The family has never been on relief.

This girl, shy and embarrassed, is sensitive about her slight speech defect. She is however reliable and good-natured, adjusting well with friends and active interests. Although her school work is satisfactory, M. is pushing herself hard for perfect achievement, an attitude clearly brought on by the mother's pushing since M.'s fifth grade failure. M. becomes confused and stutters when reciting. Although this over-ambition of the mother is predominant, it seems that the mother has babied and pampered M. too. Mother's discipline is interfered with and aided by the other sibling. Mother herself is a high-strung, nervous type.

Case 24

J., eleven years old, began to stutter three or four years ago. During the past year this stutter has become much worse. When J. is trying to get a word out, he shakes all over and shuts his eyes. He finds it hard to get started and sometimes takes two to three minutes to get out his first word. The clinic psychologist felt it advisable to use a written examination rather than an oral one, the stammering was so severe.

J. is affectionate, obedient and not irritable. He never seems to get angry but cries easily especially when mimicked and teased about his speech. J. was very upset and cried when his mother forbade his going to Mass daily so he could get more sleep. J. is a conscientious child, sensitive about his speech defect and anxious to overcome it. He is truthful and very dependable. J. is afraid of the dark and also of the water when swimming. He has to be coaxed to eat and is capricious about food.

J. makes friends easily and keeps them. He plays cops and robbers with boys in the neighborhood, mostly in his grade at school. When he has been observed at play there has been no stammering at all. Sometimes bigger boys will hit him, but he gets on well with his own friends.

Patient, now in grade six, is in the middle group of his room in lessons. He stammers badly when he tries to recite, sometimes so severely that the teacher cannot take time to hear his recitation and has him write it. J. gets on well with the other children, is apparently well liked and looked up to. J.'s former teacher in grade three reported he already had a pronounced stammer when he entered her grade. J. likes school and is very anxious to attend.

Although there is one sister younger than J., mother feels he is still the baby. Often J., waking early in the morning, will get in mother's bed and go sound asleep. Mother is extremely over-

protective of J. He is not allowed to play football or baseball as they are rough games. J.'s two older brothers tell mother she is making a "sissy" out of him. Mother does not consider him a healthy child as he complains of a sharp pain high up in his left side. Mother has even thought of keeping J. out of school for a year, so he could be calm. Discipline is left entirely to mother. She scolds J. and rarely has to punish him. Mother uses threats, but does not carry them out. Father plays and runs with the children as though a child himself, so that mother has to scold him as much as she does the children.

J. is the fourth of five children, who range in ages from nineteen years to nine. All the children are somewhat jealous of each other. J. and his younger sister are constantly accusing their parents of showing favoritism to one or the other. The younger sister always wins arguments with J. as she is more aggressive and persistent than he. J. is teased by others in the family.

Mother considers herself nervous because she cannot stand the least noise. She fears the neighbors will be disturbed if father and the children are noisy. She worries over everything but mostly health matters. Within the last four or five years mother has had a great deal of pain in her back and left side and had examinations at three hospitals. Mother is very sensitive to the opinion of others, sleeps poorly, and is impatient and irritable. Father, a fireman for fifteen years, is very easy-going and, in mother's opinion, needs to be pushed. He is very quiet, scarcely saying a word, and likes to read at home or go to the movies.

Here is a picture of a sensitive child with a severe stammer who cries easily, especially when teased about his speech. At eleven years of age, he is afraid of the dark and of water when swimming. He is apparently getting along in school and with friends despite his mother's restrictions. The mother is very over-protective of the youngest son, "the baby", and puts strong limitations on the physical activity he is allowed. Father is no help to mother with discipline, allying himself with the children rather than with her. There is jealousy among all the sibling, particularly between patient and his younger sister. Despite getting along in work and attitudes at school, J. is much handicapped in reciting by his stammer. Mother is a nervous worrying individual, sensitive and irritable.

Case 25

H., eight years old, had no difficulty with stammering until

he entered school where the stammering became worse in the first and second grades. Mother notices little difficulty at home. H. stammered some in his psychological test, but it did not interfere with results. When H. stutters badly he has spasms of the face and lips as he talks.

H. seemed a rather babyish child on first appearance, somewhat dependent on adult support. Some time ago he was afraid of the "bogey man" and would ask mother to call to him or sing. H. frequently feels there are things he would like to do but thinks he is unable. Mother feels one of his great needs is for confidence. Occasionally when H. comes home from school telling what other children have been doing, he says, "But you know I stutter, Mother." H. has been noticed biting his nails this year and has always had a tendency to suck his thumb. He was noticed sucking his thumb at clinic.

In H.'s backyard there is a hut which is clubhouse for boys in the neighborhood. Most of the boys in the group are patient's age. H. gets along well with children but is more of a follower than leader. He does not seem to be selfish or jealous when other children come into the home.

Now in grade two, H. likes school and his teacher very much. The teacher reported him as well-behaved, presenting no disciplinary problems. He has a pronounced and"painful" stammer when he "hitches and hesitates" and seems almost to choke. It is impossible for patient to tell a story or recite poetry before the class, and the teacher never calls on him for anything of this type. H. is in the lowest scholastic group, but the teacher feels he would be quite alert without his speech difficulty.

Mother has tried not to spoil H. because of his being an only child but feels that he may be a little dependent on her. Both the parents and maternal grandfather who lives in the home are very much interested in H. and like to spend time with him. The clinic psychiatrist felt that the mother much indulged H. and willingly allowed him to direct any program. There is no family discord over discipline or treatment of H., and he is never discussed in his presence. H. is an only child.

Mother, although in good health, is quite nervous. She is on the go, active in church and club work, chairman of the county health association and active in child study groups. When she is doing one thing, she is anxious to get on to the next. Father, in excellent health, is retiring, but a good mixer and amiable.

This child is apparently quite unselfconfident due in part to his feeling of being a stutterer. He gives indication of being immature in his dependence on adults and his thumb sucking, even at eight years of age. In school where his stuttering shows most severely he is rarely called on

for reciting; yet his work appears to be passing, if low. In line with H.'s immaturity there is some evidence that he, an only child, has been over-indulged despite parents' efforts to the contrary. Mother is a somewhat nervous person and on the go.

CHAPTER V

ADJUSTMENT AND ENVIRONMENT OF THE GROUP

Material on the adjustment of the children and their social functioning in various areas has been presented in Chapter IV. From an examination of these cases, it seems that in only four instances was there a comparatively good adjustment in the home, at school and with friends. Cases 1, 5, 9, and 18 seemed to show as compared with the rest of the group little or no evidence of poor social functioning. As one would expect, little or no evidence in the surrounding environmental picture emerges in the way of adverse factors in these four cases.

That twenty-five cases offer only the small number of four cases where there seems to be satisfactory social adjustment shows in general the existence of some maladjustment or adverse environment in the majority of this group. Because of the source of the twenty-five cases of this study, that is, cases referred to a child guidance clinic, it cannot be concluded that perhaps among the universe of stutterers would such a high percentage of some maladjustment be found. Although in only four cases were referral symptoms other than speech difficulty listed, one can only proceed on the assumption that a child guidance clinic, from its reputation of treating children who are maladjusted, might have chiefly those stutterers referred in whom existed other difficulties than the speech.

Considering now in more detail the twenty-one cases where the social adjustment of the child was in some measure not satisfactory, it is thought pertinent to examine this with some break-down into the various relationships in the child's life. Adjustment, of course, is a very elusive factor,

separate statements about a child's adjustment needing to be seen in the whole picture of the child's life. It is because of the loss of meaning that occurs in terms of one child's total picture when a separate element is removed from it that case summaries have been used in this paper as an initial presentation of evidence. However, with the various individual case summaries for the reader's reference, a breakdown of the child's adjustment into various areas has been made. How the classification of cases into the various categories was made can be determined by the reader in referring to case numbers in Chapter IV. There is given here some guide as to the definitions of adjustment used. Such definition is of course open to criticism, as it is difficult to say that adjustment is so black and white as good and poor. The child's adjustment with parents was characterized as poor if the child showed marked immaturity, dependence, or disobedience, or if one parent's attitude to the child contained elements of over-solicitousness, over-indulgence, or over-strictness. The relationship with sibling was classified as poor if there was undue sibling conflict or jealousy. Adjustment with friends was considered poor if the child did not have friends of his own age or get along satisfactorily with them. The child was considered as doing unsatisfactorily in school if his grades were not passing or if his behavior or attitudes were poor.

With the above definitions of adjustment in various areas, it is seen (see Table VIII) that the primary area of maladjustment of the children was in the parent-child relationship, all twenty-one cases showing some maladjustment here. The number of children showing maladjustment with sibling totaled ten. In this group of twenty-one cases, however, four were only

children. Hence, in ten of the seventeen cases who had sibling, well over half showed undue sibling conflict or jealousy. A smaller number of the group, seven out of twenty-one, showed maladjustment with friends. Only six cases out of sixteen (five children in this group of twenty-one did not yet attend grade one) showed maladjustment in school.

TABLE VIII

AREAS OF POOR ADJUSTMENT OF THE TWENTY-ONE LESS WELL-ADJUSTED CHILDREN

Area	Case Numbers	No. of Cases
With parents	All twenty-one cases	21
With sibling	7,11,12,13,14,16,17,19,20,24	10
With friends	2,3,10,13,16,19,22	7
In school	3,13,15,20,22,23	6

The main areas, then, where this group of twenty-one cases showed maladjustment were the home areas of relationships with parents and sibling. This is the "family circle" that Gifford would have examined for emotional disturbances in searching for a cause of stammering.[1] It is found in this group of twenty-one that emotional disturbances did exist of the general nature that she describes.

That the relationships with friends do not show a higher number with poor adjustment may be due to some extent to the nature of the case investigations. Those interviewed were primarily the family and the school, so that information on the child's adjustment with friends is not first hand material. If first hand investigation could be made of this area, more

1 Gifford, op.cit., p. 135.

difficulty might be revealed.

Table IX has been drawn up to analyze the predominant nature of the twenty-one poor parent-child relationships. Although in some cases a classification was more clearly indicated than in others, and although classifications to some extent overlapped, it is felt that the resulting table is valid enough to indicate a trend. The trend is, as Table IX shows, towards a prevalence of over-solicitousness or over-indulgence in the parent-child relationship. Again, the reader may examine the cases for supporting evidence.

TABLE IX

PREDOMINANT NATURE OF THE TWENTY-ONE POOR PARENT-CHILD RELATIONSHIPS

Relationship	Case Numbers	No. of Cases
Over-solicitous	2,3,12,13,14,21,22,24	8
Over-indulgent	4,6,7,8,10,20,25	7
Over-ambitious	23	1
Other	11,15,16,17,19	5
	Total	21

In the group classified as over-solicitous, cases two and three showed the mother worrying excessively about the child, in case two about health, in case three about the child's immaturity. Case twelve shows the mother fighting battles for her son with his sibling, although there are elements here of over-indulgence too because of the boy's ill-health. Case thirteen shows a mother worrying about her son, here taking on difficult situations for him and making alibis for him. In case fourteen is another

mother overly interested in her son. In cases twenty-one and twenty-four, as in cases two and twelve, the mothers are very concerned about health.

Over-indulgence is indicated variously in ineffectual or lax discipline (shown in all the cases classified as over-indulgent), often with coaxing or bribing, or by performance for the child of services he should do for himself.

Gifford searched in general for emotional disturbances. The psychoanalysts were more specific. Appelt, an analyst working in Munich, states:

> Children who grow up in an environment where they are spoiled are in the greatest danger of becoming stutterers. Only a small persentage of stutterers come from families where there is authoritative strictness.[2]

In that both over-solicitousness and over-indulgence contain elements of spoiling a child, apparently the parent-child relationships in the larger part of this group tend to substantiate Appelt's remarks that an environment where a child is spoiled put him in danger of becoming a stutterer.

Gifford questions whether the child's self-reliance is being undermined when the parents keep him dependent by waiting on him and doing for him things he should do for himself.[3] Evidence of this type of parent-child relationship shows in both the over-solicitous and the over-indulgent groups. For example, in case four the mother usually dresses and feeds her four and one-half year old son; or in case thirteen the mother holds her eight and one-half year son on her lap and babies him, or waves to him from the window until he is out of sight going to school.

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2 Eugene F. Hahn, Stuttering: Significant Theories and Therapies, p. 116.

3 Gifford, op. cit., p. 131.

The disciplining of a child is one of the important formative forces in his training. Conflict or dispute in its administration in a family is confusing to a child as well as giving him opportunity to escape from demands he does not like by going back and forth between the disagreeing authorities. In the general examination of the social picture of these children, note was made of the instances where dispute or conflict in the child's discipline existed. Discipline is of course only one of the phases where there may exist difficulty in a child's upbringing; evidence of conflict here falls only as one part of the parent-child relationship. In nine cases direct evidence of conflict about discipline appears. In three cases, this interference in discipline was caused by grandparents. In case three the maternal grandfather who lives with the family attempts to domineer the whole family and interferes and disagrees on the parents' discipline. In case twenty-one, paternal grandparents in the home negate to some extent discipline and punishments of the parents. Case sixteen shows marked interference although the maternal grandmother is out of the home. In one case, (case twenty-three), where the father has been dead ten years, the older sibling attempt to add their direction of the child to the mother's. In the other five cases parents themselves disagree or interfere with one another. Case four is most striking in showing the ill effect of conflict in discipline; parents interfere in front of one another, and the child goes from one parent to the other.

Closely related to the study of a child's adjustment with his parents is a consideration of the personalities of the parents themselves. It is commonly said that a problem child has problem parents. Aside from their

relationships with their children the personalities of the parents were examined in the case write-ups in Chapter IV. Because the mother was usually the one interviewed and seen by the social worker and psychiatrist, material about mothers is more complete than about fathers. In only two fathers was there evidence of instability, these being conspicious instances. In case six the father was in a state hospital for epilepsy. In case seventeen the father was somewhat alcoholic.

From the observations of the mothers' personalities by the clinic staff, in all cases seen first hand, the majority (twenty cases), showed attitudes or traits not in line with a happy emotionally healthy personality. In cases one, five, seven, nine and eighteen nothing appeared of the mother's maladjustment. In the other twenty cases, the kind of personality varied from nervous, worried and upset mothers to depressed, irritable and unhappy. Two mothers had definite physical neurotic symptoms--in case fourteen where the mother had had the nervous symptom of a stiff right hand for four to five years, and in case sixteen where the mother had neurotic head symptoms. Two mothers were overly meticulous about their house and housekeeping. Thus, along with a poor parent-child relationship in twenty-one cases, it is seen that the mothers themselves were nervous, worrying or high-strung.

In ten cases the marriage itself did not seem to be happy. Financial trouble contributed to this in five cases, interference of in-laws, either living in the home or near by, in three others.

Although the most valid approach to a study of personality and behavior is the non-quantitative one of case summaries, still it is interesting to

attempt to consider behavior quantitatively. From this point of view a list of twelve problems of behavior has been made and the frequency of occurrence of each of these through the group considered. (See Table X) The case evidence on each of these problems of behavior has been given in each case write-up. However, for the reader's guidance here is some definition of the problems of behavior included in a few of the more general classifications. A child was classified as having a problem if the problem behavior occurred either in the present or in the past. Feeding difficulty includes such case descriptions as "sick spells caused by upset stomach and a very poor appetite", "food-capriciousness", "sometimes has to be coaxed about eating and has a small capacity", or "during infancy... continual nutritional difficulty and did not eat properly until four years of age". Enuresis includes either nocturnal or diurnal enuresis after three years of age. Some sleep disturbances were, for example, "grinds teeth at night", or "has occasional night terrors".

Although Table X makes no allowance for the seriousness of a problem, and although it is very true that soiling, for example, is considerably more serious than nailbiting, it is thought worthwhile to consider the information in Table X from the viewpoint of frequency of occurrence of problems of behavior in the group as a whole. Table XI is presented from this standpoint. Here it can be seen that only two children had no problems of this nature, only five had only one. This means that eighteen of the children, a large majority of the group, had two or more such difficulties. A little more than one-half of the group, thirteen children, had three or more problems. The occurrence of any of these twelve problems in

a child's life, even taken out of his general picture, is an indication that some disturbance or maladjustment may be operating. Therefore, the existence of a large majority of children with two or more such problems is another way of stating what was stated earlier in this chapter, that this group as a whole shows definite maladjustment.

TABLE X

OCCURRENCE OF PROBLEMS OF
BEHAVIOR IN THE TWENTY-FIVE CHILDREN

Problem	Case Numbers	No. of Cases
Feeding difficulty	2,4,6,7,8,9,10,13,14,15,16, 17,19,20,24	15
Nail biting	9,10,12,13,15,18,20,21,22, 23,25	11
Temper tantrums	4,7,8,10,13,16,17,19,22	9
Thumbsucking	4,9,12,13,16,25	6
Enuresis	3,8,10,11,14,17	6
Cries easily	11,12,13,16,22,24	6
Sleep disturbance	2,7,11,12,13	5
Fears	19,24	2
Masturbation	4,11	2
Other sex activity	11,22	2
Soiling	11	1
Vomiting	2	1

TABLE XI

NUMBER OF PROBLEMS OF BEHAVIOR PER CHILD

No. of Problems	Case Numbers	No. of Cases
0	1,5	2
1	3,6,18,21,23	5
2	9,14,15,20,25	5
3	2,7,8,17,19,24	6
4	4,10,12,16,22	5
5		0
6	11,13	2

To consider again Table X, its predominant feature is that the most frequently occurring problem is feeding difficulty. Referring to the study made by Despert (mentioned in Chapter II) it is recalled that she found in her group of fifteen a predominant number of cases where feeding difficulty occurred. From this she concluded that not enough emphasis had been placed on the oral level of functioning of stutterers. The number of children found in this present study who presented feeding problems, 60 per cent, is not so strikingly high as hers, but assumes significance when compared to the numbers of children showing other problems. The next highest ranking problem, nail biting, occurred in less than one-half of the group.

Comparison of this disturbance in an oral function with the frequency with which the problems of enuresis and soiling were found is interesting in the light of psychoanalytic theory. The problem of enuresis or soiling occurred in only six cases as compared with the fifteen cases of feeding

difficulty.

An examination of the length of time the group was breast-fed was made to see if any further substantiation of deviation in oral history was detectible. Results are shown in Table XII. English and Pearson state that an optimum length of time for breast feeding is about nine months.[4] It is seen that sixteen cases out of twenty-two where information was available were breast-fed six months or less. There is evidence, here then, that about 73 per cent of the group was subjected to some curtailment of breast feeding. English and Pearson stated it is found that in most cases of stutterers there has been a curtailment of breast feeding.[5]

TABLE XII

LENGTH OF TIME GROUP WAS BREAST-FED

Length of Time in Months	No. of Cases
No breast feeding	2
Through 3 months	6
3 through 6 months	8
6 through 9 months	4
9 through 12 months	1
Longer	1
Unknown	3
Total	25

A consideration of the age when toilet training was achieved for the group revealed no particular trends. (See Table XIII) Taking one and one-half to two years as an arbitrary time for achieving toilet training, it is found that eight cases were trained before this time and seven after.

4 English and Pearson, op. cit., p. 26.

5 Ibid., p. 108.

TABLE XIII

AGE WHEN TOILET TRAINING WAS ACHIEVED

Age	No. of Cases
½ year through 1 year	3
1 year through 1½ years	5
1½ years through 2 years	6
2 years through 2½ years	1
After 3 years	6
Unknown	4
Total	25

So far in this chapter, the case material on this group has been considered without reference except in a general way to the fact that the children stuttered. It is the writer's intention now to look at the material from the viewpoint of seeing where in these children's lives their speech difficulty was playing a part. As in the examination of the adjustment of the children, the material has again been divided off into various areas of the child's life, and the role that the stutter played in the child's relationships at home, with friends and at school has been considered.

Looking first at the parent-child relationship where in twenty cases the children were found to have a poor adjustment, a survey of the case material shows five cases where the stutter was a part of this poor relationship. In cases three, thirteen, fourteen, sixteen, and twenty-one the mother, or mother and father, were very concerned, upset, or sensitive about the child's stutter. It would seem then, that in the majority of cases the parental attitude to the speech was apart from the poor parent-child relationship; in other words, that there existed an unhealthy relationship with a parent without the factor of the child's stutter.

In the children's relationship with their sibling in only two cases of the ten who showed a poor adjustment with sibling was the speech part of the poor relationship. In case nineteen the younger, but more articulate brother irritates the stutterer and takes conversation from him when he stutters. In case twenty an older brother laughs at the stutterer's speech. Other than these two cases, it does not appear in the material that the existing stuttering plays a part in the sibling conflict or jealousy.

In their relationships with friends in three cases, cases two, three, and thirteen, evidence shows the stutter interfering.

It is interesting and understandable that in the school situation more than in any other evidence appears on the role of the stutter. The school classroom with its reciting and oral work presents to the stutterer a situation where he cannot avoid speaking. Out of the twenty-five cases studied, twenty attended grade school. Of these twenty cases, in fifteen was evidence present of an adverse effect that the speech difficulty played in the child's school life. In some cases the children hesitated to volunteer or recite or spoke in too low a tone to be understood. In other cases the teacher refrained from calling on the child as much as she should because of his difficulty when reciting. Other children were confused, self-conscious or otherwise disturbed in reciting.

The definition for school adjustment as formulated for Table VIII can be of course criticized. However, accepting as a definition of maladjustment in school that of not doing passing work or having poor attitudes or behavior, the small number of cases with poor school adjustment, six cases,

is interesting when the amount of disturbance from the stuttering is noted.

In summary, this consideration of the role of speech in the school life of the children reveals that in three-fourths of the total twenty cases attending grade school the speech interfered with their school activity although only slightly over one-fourth of the group showed poor school adjustment.

As stated in Chapter 1, besides the main investigation of personality, adjustment, and environment of this group of twenty-five stutterers, the writer proposed to examine the cases for some specific factors which have been thought by some investigators to be underlying or contributing to the difficulty of stuttering.

Wedberg in his autobiography describes clearly the confusion he remembers in his childhood when he struggled with two languages, Swedish, his parents' native tongue, and English.[6] The Blantons[7] and many other investigators feel that the learning of a second language at the same time the first one is being learned may be a contributing factor to stuttering. In the present group being studied, seven homes were found where two languages were spoken. Without a control group and a much larger number of cases, this figure has little meaning except to indicate that in a little over one-fourth of this group this possibly contributing factor existed.

In line with the work of Orton and Travis on hand-conversion and cerebral dominance, the number of children in this group in whom an enforced shift of handedness had occurred was noted. This was reported in

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6 Conrad F. Wedberg, The Stutterer Speaks, p. 14.

7 Smiley and Margaret Blanton, op. cit., p. 85.

four cases in the material. Two more children were reported ambidextrous without note of the specific fact of enforced change. In Orton's studies and in that of others working carefully from this approach[8] handedness was investigated not only by history-taking but also by special tests such as motor lead tests. The material of this study as explained in Chapter I was secured from social histories and psychological, psychiatric, and speech examinations. The psychological examinations were almost entirely intelligence tests, and in these careful observation of the child's handedness in such general performances as writing was observed. However, special tests for hand usage were not given. Thus the investigation of this study into handedness can in no way be considered a complete one.

The history of past or present stuttering in a parent, uncle, aunt or grandparent in this group occurs in a larger number of cases than does enforced hand conversion. In fifteen cases such a history was found. This coincides with Robbins' statement that statistics show that one-half of all stammerers have one or more relatives who have stammered.[9]

Combining, as does Orton, the cases where either an enforced shift of handedness from left to right hand took place or there was a family history of stuttering,[10] it is found that seventeen cases contained one or both of these two factors. Considering the size of the group, twenty-five cases, this number of seventeen cases is not far different from the number of

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8 See, for example, W. Johnson and A. King, "Angle Board and Hand Usage Study of Stutterers and Non-stutterers", Journal of Experimental Psychology, 31:293-311, October, 1942.

9 Robbins, op. cit., p. 7.

10 Orton, op. cit., p. 125. See also supra, p. 12.

cases (twenty-one) where maladjustment or adverse social factors were found. Remembering that the selection of this group, as child guidance clinic cases, possibly contained a weighting of maladjustment in the children, the evidence appears to indicate quite as much backing for the theory that a family history of stuttering or enforced hand-conversion underlay the stuttering as for the theory that emotional disturbance was the underlying factor

CHAPTER VI

SUMMARY AND CONCLUSIONS

Studies of stuttering and stutterers have approached from many angles in an attempt to gain knowledge of the origins and effects of this difficulty which statistics indicate is likely to affect one child in every hundred. From these varying approaches, psychological, psychiatric, physiological, and social, different material and conclusions about stutterers emerge.

This present study is made from the social approach of examining the lives of children who stuttered. Observation of the children's personality, adjustment, and behavior traits were made, including their relationships in the home, with friends and in school. Information about the effect of the stutter on their social relationships was noted where possible.

Data of the study were furnished from twenty-five case records at the Massachusetts Child Guidance Clinics, chosen consecutively out of the files from cases referred between March, 1937, and February, 1938. Selection of cases included all those cases where stuttering occurred, provided the case had been taken for "full service" treatment and that a speech examination had been given.

A schedule (see appendix), so arranged as to examine the case material on the personality of the child, past and present behavior and adjustment, and the family make-up and relationships with the child was formulated and carried through in each case.

Evidence indicated that out of this group of twenty-five twenty-one cases showed maladjustment of the children in some sphere and adverse

environmental pressures. It can be concluded that in this group in the majority of cases a poor social adjustment was being made. Thus the prevalence of poor social functioning as a contributing or underlying factor in the lives of stutterers in this particular group is illustrated. However, the possibility exists that this group, referred to a child guidance clinic, may have the selective factor of being maladjusted children although in all but four cases the referral was made only on the basis of the speech difficulty.

An examination of the areas of maladjustment showed in twenty-one cases that the parent-child relationship was not of an emotionally healthy sort. In fifteen of these twenty-one cases, the parent, chiefly the mother, was either over-solicitous or over-indulgent with the child. The mothers themselves were in twenty cases found to be nervous, worried individuals, or unhappy, irritable or depressed.

One of the most interesting findings about the children themselves was revealed by a study of their past and present behavior problems. The most prevalent behavior problem was found to be feeding difficulty, either past or present, which occurred in fifteen cases. In the light of other studies and psychoanalytic theory, this appears to high-light the importance of a disturbance of an oral nature, indicating the relationship between the oral activity of talking and the oral activity of eating. Further, the examination of the length of breast-feeding in the group indicated that the group as a whole had been subjected to a curtailment of breast feeding to less than the optimum length of time.

The primary area where stuttering interfered in the child's life was

found to be the school. Here fifteen cases of the twenty attending grade school had their school activity interfered with by their speech. Yet in only six cases was there unsatisfactory school work or unsatisfactory attitudes among the children.

Besides poor social adjustment and adverse social influences, the factors of inheritance of speech defect or enforced shift of handedness occurred in seventeen cases, a large majority of the group.

In summary, it may be concluded:

(1) In the majority of this group of stuttering children, poor social adjustment or adverse environmental factors existed which might be contributing to or underlying their difficulty of stuttering.

(2) The main kind of poor parent-child relationship found was over-indulgence or over-solicitousness, indicating that these parent-child relationships may be more predisposing to the development of a stutter than other parental attitudes.

(3) A history of deviation in an oral sphere shown both by the presence of feeding difficulty and the curtailment of breast-feeding may be an important factor in the history of stuttering children.

(4) Stuttering in children apparently affected them more in the school situation than in any other.

(5) The presence of relatives with stuttering difficulty or an enforced shift of handedness in the child occurred in the history of a majority of these children as a possible contributing or underlying factor in their stuttering.

Approved,
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Richard K. Conant, Dean

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APPENDIX

SCHEDULE

Name
Sex

Referral Source
Referral Problem
Age at Referral

Speech Difficulty
- Onset of Stutter
- Description of Speech

Child:
- Early History
- Feeding History
- Toilet Training
- Talking
- Sexual Development
- Other Problems of Behavior
- Health History
- Handedness

Child:
- Present History
- Personality of Child
- Friends
- Interests
- School
  - Grade
  - Scholarship and Attitudes
- I.Q.

Family:
- Uncles, Aunts, Grandparents
  - Speech Defect
- Mother
  - Personality
  - Speech Defect
  - Attitude to Stuttering
- Father
  - Personality
  - Occupation
  - Speech Defect
  - Attitude to Stuttering
- Parental Relationship
  - Relationship to Each Other
  - Discipline of Child
  - Mother-Child Relationship

(Schedule - continued)

Father-Child Relationship
Sibling
    Number
    Relationship with Child
Nationality of Home
    Languages Spoken